HOLISTIC DENTISTS

TRIBECA CENTER FOR

INTEGRATIVE HOLISTIC DENTISTRY

PATIENT REGISTRATION

*To assist us in serving you, please **complete** the following confidential form.*

PATIENT'S INFORMATION

Patient's Name _____ **Sex:** ❑ **Male** ❑ **Female**

Date of Birth _____ **Social Security #** _____

Mailing address _____ **City** _____**State** ____ **Zip** _____

Home # _____ **Work #** _____ **Mobile #** _____

Email Address_____ **Marital Status:** ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Widow**

Referred by ❑ **Google** ❑ **Website** ❑ **Newspaper** ❑ **TV** ❑ **Other:** _____

What brings you to our office today?_____

_____

INSURANCE INFORMATION

Employer _____ **Occupation** _____

Subscriber's Name _____**Date of Birth** _____ **Social Security #** _____

Primary Dental Insurance _____ **Member ID #**_____ **Group #** _____

Primary Dental Insurance Phone Number _____

Primary Subscriber's Address _____ **City** _____**State** ____ **Zip** _____

Patient Relationship to Subscriber _____

Medical Health History

Do you have or have you had any of the following?
(Please check any that apply)

❑Cancer or tumor
❑HPV Type:___
❑Heart ailment or angina
❑Heart murmur, mitral valve prolapse, heart defect
❑Rheumatic fever or rheumatic heart disease
❑Artificial joint or valve
❑High or low blood pressure
❑Pacemaker
❑Tuberculosis or other lung problems
❑Kidney disease
❑Hepatitis or other liver disease
❑Alcoholism
❑Blood transfusion
❑Diabetes
❑Neurologic condition
❑Epilepsy, seizures, or fainting spells
❑Emotional condition
❑Arthritis
❑Herpes or cold sores
❑AIDS or HIV positive
❑Migraine headaches or frequent headaches
❑Anemia or blood disorders
❑Abnormal bleeding after procedures
❑Hay fever or sinus trouble
❑Allergies or hives
❑Asthma

Are you allergic to, or have you reacted adversely to any of the following?

❑Latex materials
❑Penicillin or other antibiotics
❑Local anesthetics ("Novocain")
❑Codeine or other narcotics
❑Sulfa drugs
❑Barbiturates, sedatives, or sleeping pills
❑Aspirin
❑Other:_____

Are you taking any of the following?

❑Aspirin
❑Anticoagulants (blood thinners)
❑Antibiotics or sulfa drugs
❑High blood pressure medicine
❑Antidepressants or tranquilizers
❑Insulin, Orinase, or other diabetes drug
❑Nitroglycerin
❑Cortisone or other steroids
❑Osteoporosis (bone density) medicine
❑Other:_____
_____

Women:
❑May be pregnant
Expected delivery date: _____
❑Taking hormones or contraceptives

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Dental Health History

Are you apprehensive about your treatment?	❑ yes ❑ no	Does your jaw make noise?	❑ yes ❑ no
Do you gag easily?	❑ yes ❑ no	Do you grind or clench your jaw/teeth?	❑ yes ❑ no
Do you wear dentures?	❑ yes ❑ no	Does it hurt when you chew or open wide?	❑ yes ❑ no
Does food catch between your teeth?	❑ yes ❑ no	Do you have pain in cheeks, jaws or joints?	❑ yes ❑ no
Do you have difficulty in chewing food?	❑ yes ❑ no	Do you chew on one side of your mouth?	❑ yes ❑ no
Do you avoid brushing because of pain?	❑ yes ❑ no	Are you habitual gum chewer or pipe smoker?	❑ yes ❑ no
Do your gums bleed when you floss?	❑ yes ❑ no	Do you take fluoride supplements?	❑ yes ❑ no
Do your gums feel swollen or tender?	❑ yes ❑ no	Are you satisfied with your smile?	❑ yes ❑ no
Are your teeth sensitive?	❑ yes ❑ no	Do prefer to save your teeth?	❑ yes ❑ no
Do you have silver/mercury fillings?	❑ yes ❑ no	Other: ……..	

Sleep Quiz

❑I snore
❑I wake up tired
❑I wake up gasping
❑I wake up with sore throat
❑I have trouble losing weight
❑I frequently wake up to use the bathroom
❑It is hard for me to stay awake when while driving.
❑I've been told that its incredible just how fast I fall asleep
❑I've been told that I'm restless sleeper with my arms and legs flying all over the bed
❑I wake up with pain and numbness in my legs
❑I have difficulty falling asleep or staying asleep
❑I've been told that I stop breathing while I sleep

If you checked any of these boxes, you may have sleep apnea or another sleep disorder. Please discuss with your dentist today!

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We want to inform you that we are a OUT of NETWORK provider with all dental PPO plans except Delta Dental Premier.

We strive to provide you with the best dental services in the timeliest fashion; in order to achieve this goal, we need to gather all the information necessary to develop a successful, long term relationship and assure you utilize all of your dental benefits through your dental carrier. We understand no one likes to be surprised when it comes to financial matters. Therefore, we need your assistance and your cooperation with our payment policy. We have agreed to accept assignment of benefits from most major insurances as a courtesy as long as you are eligible for benefits on the date of service. We ask you to leave a credit card number on file for any outstanding balance and co-pays.

FINANCIAL POLICY

For your convenience we accept Visa, MasterCard, Amex and Discover, checks and cash as of method of payment. We also accept financing through Care Credit.

MISSED APPOINTMENT AND CANCELLATION POLICY

We have scheduled your appointment and it is reserved just for you; therefore, a 24-hour notice is required for any cancellation.

A fee of $75 will automatically be charged for missed or same-day canceled appointment. We reserve the right to charge the credit card on file or apply your previous deposit towards this cancellation fee.

ALL PATIENTS MUST COMPLETE THIS PART

❑ VISA ❑ MASTERCARD ❑ AMEX ❑ DISCOVER Billing Zip Code_____

_____ _____ _____

Credit Card Number Exp. Date V-code

_____

Cardholder Name

_____ _____

Patient's Signature (or Guardian) Date